STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155683	A. BUILDING 00 B. WING	06/06/2011

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B & B CHRISTIAN HEALTHCARE CENTER	3208 N SHERMAN DR INDIANAPOLIS, IN46218

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F0000	This visit was for a Recertification and State Licensure Survey. Survey Dates: May 31, June 1-6, 2011 Facility Number: 011032 Provider Number: 155683 Aim Number: 200262860 Survey Team: Diana Zgonc RN TC Connie Landman RN Courtney Hamilton RN Christi Davidson RN Suzanne Williams RN (May 31, June 1-3, 2010) Census Bed Type: SNF/NF: 7 NF: 25 Total: 32 Census Payor Type: Medicaid: 32 Total: 32 Sample: 28 (Stage 2) These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000	Please accept this plan of correction as my credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed 6/9/11 Cathy Emswiller RN			
F0221 SS=D	The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Based on observation, record review and interview, the facility failed to ensure residents were assessed for and free of unnecessary restraints for 2 of 2 residents reviewed for restraints in a Stage 2 sample of 28 (Residents #27 and #19). Findings include: 1. A current facility policy, dated 6/9/08, titled "(Name of Facility) Policy on Restraints", provided by the DON (Director of Nursing) on 6/6/11 at 9:00 A.M., indicated: "... Policy: It is the policy of (Name of Facility) to strive to be restraint free, however, due to the medical conditions of, some of our residents, lap buddies may be used to ensure	F0221	The entire facility was checked for the use of any forms of restraints. If any restraints were in use, the resident's chart was audited for assessments, physician's orders, family consent, care plans, and documentation to support the use of any types of restraints.The residents involved were assessed for use of restraints. This was discussed with the Physcian, physical therapy, and the resident's family. Proper documentation was put in place on each of the residents involved and each use of a restraint was care planned.A restraint book will be placed at the nursing station with the restraint policy and these steps must be followed before a restraint is applied: 1. Documentation for use of a restraint (assessments and care plans). 2. M.D. Order and	06/15/2011

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	the residents safety.... ... 2. A physician's order must be obtained before the use of the lap buddy. 3. The resident must be assessed before the use of the lap buddy. 4. The resident's family, guardian, or involved representative will be contacted when lap buddy is utilized.... ... 6. No form of restraint will be used without notifying the family even with a physicians order." 2. An undated current facility policy, titled "Side Rails" provided by the DON on 6/6/11 at 9:30 A.M., indicated: "... Side rails used to restrict the resident's freedom of movement are considered restraints. Side rails used to assist the resident in turning or to help the resident get out of bed are not a restraint.... ... 2. An assessment will be performed to determine if full length siderails are needed to treat medical symptoms. Use of full side rails require a physician's order. 3. Check residents at least every two hours frequency. Check restraint policy/procedure for frequency of checking restraint devices...." 3. The record for Resident #27 was		reason for use of a restraint 3. Family consent 4. A restraint release form, if needed.The restraint book will be monitored by the D.O.N., the A.D.O.N., and the charge nurse. Any new restraint order will be immediately reported to the D.O.N. before it is put in place. The Q.A. Committee will monitor the use of restraints on a quarterly basis. This will remain in place for 1 year.	

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	reviewed on 6/2/11 at 9:35 A.M. Current diagnoses included, but were not limited to, diabetes mellitus, dementia, Alzheimer's Disease with aggression, glaucoma, hyperlipidemia, gastroesophageal reflux disease, depression, and hypertension. The June, 2011, Recapitulation of Physician's Orders indicated a lap buddy was to be used when up in wheel chair for "safety".. Had been originally ordered on 4/18/11 as a telephone order at 1:00 P.M. During observations of Resident #27 on 05/31/11 at 12:00 P.M., 06/01/2011 at 8:00 A.M., and 09:03 AM a lap buddy was in place in Resident #27's wheel chair during lunch on 5/31/11 breakfast at 8:00 A.M., and again at 9:00 A.M. while she was in her room. The Nurses Notes from 4/5/11 through 4/22/11 did not indicate a reason the lap buddy was ordered. No fall was documented. No constantly rising from chair had been documented. Resident #27's record lacked documentation of a Restraint Assessment, a Consent for use of a			

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	restraint, or a Restraint Record which would document the times the resident had been restrained and released from the restraint. The record also lacked a Care Plan for the use of a lap buddy, the last review date for the current care plans was 4/6/11. The physician's order lacked a medical reason or indication for the use of the lap buddy restraint. The Fall Risk Assessment, dated 4/5/11, indicated no history of falls, had balance problems during transitions, leaned forward at times once in the wheel chair, The analysis of findings indicated "Res. (resident) has no recent, documented falls, but does have reduced safety awareness 2 (secondary to) dementia. Also @ [at] risk due to vision & use of lexapro (an antidepressant) on a daily basis." On 6/2/11 at 10:45 A.M., during an interview with the DON, she indicated she was unable to find a restraint assessment, care plan, consent, or restraint documentation. During an interview with the DON on 6/2/11 at 1:45 P.M., she indicated the lap buddy was put on without an assessment or documentation or consent being done. 4. Resident #19's record was			

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	reviewed on 06/02/2011 at 1:00 PM. Diagnoses included, but were not limited to, dementia, hypertension and encephalopathy. On the following dates resident #19 was observed lying in bed with 2 full side rails up with the bed against the wall: 05/31/2011 at 11:40 AM, 06/01/2011 at 8:40 AM, and 06/02/2011 at 10:20 AM. A current Minimum Data Set (MDS) assessment dated 02/24/2011 indicated resident #19 had not had a fall since admission and required the use of bed rails daily. The MDS indicated the resident was totally dependent on staff assistance for bed mobility, transfers, dressing and toileting. A current care plan dated 03/09/2011 indicated resident #19 was at risk for falls secondary to cognitive impairment. Interventions included, but were not limited to, bed in low position and AROM [active range of motion]. The care plan indicated the resident was unable to turn/reposition independently. There was no care plan for the use of restraints. A physicians order dated 04/18/2011 indicated resident #19 was to have			

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	"side rails up when in bed." The record lacked documentation for the reason the side rails were ordered, a current consent for the restraints, or a restraint flowsheet. An interview with CNA #1 on 06/02/2011 at 10:20 AM indicated the resident was a fall risk and that was the only way she could have the side rails up. An interview with the Director of Nursing (DON) on 06/02/2011 at 1:15 PM indicated the resident scoots and moves around in bed and that was why the side rails were up. 3.1-26(o)			
F0241 SS=D	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.			

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	Based on observation, record review and interview, the facility failed to ensure a resident was transported in her gerichair in a manner to enhance and promote the resident's dignity for 1 of 28 residents observed for dignity issues in the stage 2 sample of 28 (Resident #19). Findings include: 1. During observation of the lunch meal in the main dining room on 5/31/11, Resident #19 was pulled down the hall between the front entrance and the dining room backward in a gerichair by CNA #2. The resident's name was written in black marker on the chest area of her T-shirt. 2. On 05/31/11 at 12:15 P.M., resident #19 was observed being pulled backwards in the geri-chair into the dining room to the table. 3. On 06/01/2011 at 8:36 A.M., resident #19 was observed being pulled backwards in her geri-chair by CNA #1. The resident was yelling out. 4. On 6/1/11 at 2:00 P.M., Resident #19 was observed in a geri-chair being pulled down the hallway backwards. This was called to the	F0241	All residents were assessed for the use of gerichairs/wheelchairs. An inservice was given to all nurses and c.n.a.'s covering the proper transportation of residents in gerichairs/wheelchairs. The entire nursing staff was also inserviced over the proper labeling of resident's clothing.All residents were identifed as having the potential to be affected by this deficient practice.A new policy regarding the transportaion of residents in a gerichair/wheechair has been put in place. Any employee that does not adhere to the policy will face the following discipline: verbal warning, written warning, 3 day suspension, and if the deficient practice continues the employee will be terminated.To further ensure the dignity of all residents, the staff and resident family members have been informed of the proper labeling placement on resident's clothing.The transportation of residents in gerichairs/wheelchairs and the proper labeling of resident's clothing will be monitored by all nursing staff on a daily basis. This will be reviewed quarterly by the Q.A. Committee.	06/14/2011

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	SSD's (Social Services Director) attention who went down the hall to speak to the CNA. The SSD was informed there had been 4 observations of Resident #19 being pulled backwards in the geri-chair. 5. Resident #19's record was reviewed on 06/02/2011 at 1:00 PM. Diagnoses included, but were not limited to, dementia, hypertension and encephalopathy. A current Minimum Data Set (MDS) assessment dated 02/24/2011 indicated resident #19 had not had a fall since admission and required the use of bed rails daily. The MDS indicated the resident was totally dependent on staff assistance for bed mobility, transfers, dressing and toileting. A current care plan dated 03/09/2011 indicated resident #19 was at risk for falls secondary to cognitive impairment. Interventions included, but were not limited to, bed in low position and AROM [active range of motion]. The care plan indicated the resident was unable to turn/reposition independently. The care plan indicated the resident required a geri-chair while in sitting position to prevent inappropriate posture, ie: leaning forward. The care plan			

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	indicated the resident had an alteration in ability to communicate related to her impaired vision, impaired hearing, impaired speech, and impaired cognitive abilities. The care plan indicated resident #19 would yell out for hours. An interview with the DON on 06/02/2011 at 10:30 AM indicated the incidents of pulling the resident backward in the chair was not appropriate. 3.1-3(t)			
F0248 SS=D	The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observation, record review, and interview, the facility failed to ensure activities met individual resident interests for 1 of 3 residents in a sample of 6 who met the criteria for activities. (resident #17)	F0248	Resident #17 was interviewed extensively about his activity likes and dislikes. These were documented and the documentation was signed by resident #17.A new activites preference sheet was put in place by the Social Services Director. In order to determine a resident's	06/17/2011

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	Findings Include: The record for Resident #17 was reviewed on 06/02/11 at 8:45 a.m. Diagnoses included, but were not limited to, osteoarthritis, glaucoma, Alzheimer's disease, dementia, hypertension, diabetes, prostate cancer, and unavoidable weight loss. A significant change Minimum Data Set (MDS) Assessment dated 03/17/11 indicated on the cognitive assessment portion, Resident #17 identified the accurate day, the accurate month within 5 days, and the accurate year. The MDS indicated Resident #17 had not presented behaviors or mood concerns during the assessment phase. The MDS indicated Resident #17 had not exhibited rejection of care. The activity assessment was marked that Resident #17 indicated activities were not important at all. A care plan with the most recent date of 03/30/11 indicated a goal of, "...Resident will be provided with the opportunity to develop new interests {and} allowed to decline as he desires x 90 d {times 90 days}...." Interventions included, but were not limited to, "...Invite to group activities.		activity preferences, all residents or family members were interviewed. The residents, who could sign for themselves, signed the documentation. A family member signed the documentation for the residents who could not sign for themselves.Each individual resident's likes and dislikes will be care planned. Low functioning residents will have one on one interaction with an activities assistant. An activities assistant also will direct evening activities from 5-8pm daily. All resident's attendance and participation in activities will be documented. This documentation will be monitored weekly by the Social Services Director, the D.O.N., the charge nurse, or the Administrator. This will be reviewed quarterly by the Q.A. Committee.	

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	Provide activity calendar...monitor for s/s {signs and symptoms} of depression {and} report. Encourage interaction {with} peers." **During an interview on 06/01/11 at 8:50 a.m., Resident #17 indicated there were no evening activities.** The Activity Log record lacked documentation of Resident #17's activity participation from 04/20/11 through 05/31/11. During an interview on 06/02/11 at 1:30 p.m., the Activities/Social Services Director indicated resident #17 was invited to all the scheduled facility activities. She indicated there were activities at least two times a week in the evenings. During an observation on 06/02/11 at 1:45 p.m., a large activity calendar posted outside the main dining room indicated on 06/01/11 at 6:00 p.m. a movie, on 06/02/11 at 6:00 p.m. a movie, on 06/06/11 at 6:00 p.m. a movie, on 6/15/11 at 6:00 p.m. a movie, and on 06/20/11 at 6:00 p.m. a movie. No other evening activities were noted in the evening for the month of June.			

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	During an interview on 06/02/11 at 2:50 p.m., the Activities/Social Service Director indicated the movie was started by someone working, for example, a nurse. She indicated she leaves the movie at the facility and someone starts it. The movies are played and watched in the main dining room. During an interview and observation on 06/03/11 at 10:45 a.m., Resident #17 showed his boy scout patches and indicated he was a chaplain for the boy scouts. He indicated he went on several boy scout camping trips. During an interview on 06/03/11 at 12:30 p.m., the Activities/ Social Service Director indicated, when inquiry was made about Resident #17 attendance at activities, "Can you get him to go?" She indicated the resident was offered facility activities, but refused to attend. She indicated Resident #17 was "belligerent." She indicated she had seen the resident's boy scout patches, but no attempts to meet this interest had been made. During an interview with the DoN on 06/03/11 at 2:00 p.m., the DoN indicated she was not aware Resident #17 was a boy scout and interested in boy scouts.			

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	3.1-33(a)			
F0253 SS=C	The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to ensure bathrooms, hallways, shower room, and 9 of 22 patients rooms were clean and in good repair. This had the potential to affect 9 of 22 resident rooms and the two shower rooms, main hallways,	F0253	Rooms 1 & 2: - nightstands were replaced. - bathroom walls were fixed and painted - over the bed table was replaced - room was painted - toilet paper dispenser was replaced - exhaust fan was repairedRooms 3 & 4: - nightstand was replaced -	06/30/2011

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	and dining room. (Rooms #1, 2, 3, 4, 10, 14, 17, 21, 8) Findings include: 1. On 05/31/2011 at 4:15 PM, observation of room #1 indicated a marred nightstand with the knob missing, marred base of the overbed table, marred walls and doorway. There were stained tiles around the toilet, marred walls and doorway in the bathroom. 2. On 05/31/2011 at 3:43 PM, observation of room #2 indicated scraped and marred doors and walls, and dirty closet doors. In the bathroom, when the light was turned the exhaust fan ran very loudly. There was no toilet paper dispenser. There was a hole in the wall where on once was. There were dark stains in the grouting between the tiles around the toilet. 3. On 05/31/2011 at 4:11 PM, observation of room #3 indicated a marred and scrapped nightstand, marred doorway, walls, and floors. There were dark stains in the grouting between the tiles around the toilet. 4. On 05/31/2011 at 4:22 PM, observation of room #4 indicated		grouting was cleaned - room was painted - toilet was repaired - bed frame was repaired and painted - toilet paper dispenser was replaced - tile around toilet was replacedRooms 5 & 7: - toilet paper holder was replaced - tile around toilet was replaced - room was paintedRooms 6 & 8: - toilet paper holder was replaced - tile around toilet was replaced - the patchwork under the sink was sanded and painted - the bed by the door in room #8 was replaced. Room 10: - the door was replaced - the floor was cleanedRoom 14: - tissue box was replacedRoom 17: - tile around toilet was replacedRoom 21: - the door was repaired - the floor was cleanedSouth Shower Room: - the shower was repaired - the shower was re-tiled and painted - the grouting was cleaned - the shower chair and faucets were thoroughly cleanedNorth Shower Room: - the shower was renovated and painted - the fixtures were cleaned - the cover on the light was fixed - all shower chairs were thoroughly cleaned - the toilet paper dispenser was repairedHallways: - the halls were drywalled and painted, where needed - the threshold was cleaned and painted - the television was repaired - new over the bed tables were placed in the dining room - the dining room was thoroughly cleaned and painted - the windows and the	

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	marred walls and doorway, a scraped up bed frame with paint missing. There were stained tiles around the toilet in the bathroom. 5. On 06/01/2011 at 8:43 AM, observation of the bathroom shared between rooms 5 and 7 indicated dark stains around base of toilet, stained tiles, scuffed walls, and a loose and crooked tissue dispenser. 6. On 06/01/2011 at 9:07 AM, observation of the bathroom shared between rooms 6 and 8 indicated dark stains around the base of the toilet, missing inner tube for the toilet paper dispenser with toilet paper sitting on the back of the toilet, repair work done underneath the sink. The patch work was not sanded or painted. 7. On 06/02/2011 at 8:30 AM, observation of room 8 indicated the bed by the door was broken and cracked at the foot of the bed and was repaired with duct tape. 8. On 06/02/2011 at 8:30 AM, observation of room 10 indicated the door stuck to the floor and was difficult to open or close. There were gouge marks on the floor from the door.		doors in the dining room were cleaned - the blinds in the dining room were replacedAll residents have the potential for being affected by this deficient practice. However, all other resident's rooms were found to be sanitary, orderly, and comfortable.A new housekeeping log will be put in place to check the entire building monthly for repairs and cleaning issues.This will be monitored monthly by the Maintenance Supervisor and the Administrator. The housekeeping log will be signed by both. The housekeeping log will be monitored quarterly by the Q.A. Committee.	

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	9. On 05/31/2011 at 12:15 PM, observation of room 14 indicated a metal tissue box dislodged from the wall. 10. On 05/31/2011 at 3:10 PM, observation of room 17 indicated cracked tiles around the base of the toilet with standing water. 11. On 06/01/2011 at 9:06 AM, observation of room 21 indicated the door stuck to the floor and was difficult to open or close. The door made a very loud sound when being opened. There were gouge marks in the floor from the door. During the environmental tour on 06/02/2011 at 8:30 AM, observations included: 1. The south shower room indicated cracked tiles, walls dirty with peeling drywall around the soap dispenser, dirty sink with dried toothpaste, corrosion around the faucet, a dirty shower chair in the shower, cracked and missing caulk around the tile in the shower and on the floor in the shower. There was cracks on the walls and ceiling repaired with caulk. The repair work was not sanded or painted.			

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	2. The north shower room indicated a dirty and soiled shower chair, peeling, cracked and stained tiles, cracked tiles on the floor with water dripping from the shower head, water stains on the wall under the faucet. The cover on the light on the ceiling was dirty, broken and hanging off the light in the shower. There was peeling drywall around the soap dispenser, cracked wall around the toilet. The toilet was dirty and the toilet paper dispenser was hanging partially off the wall. 3. The hallway leading from the entrance to the dining room indicated crack and peeling caulk that was not sanded or painted. The ceiling was bowed in around the door to the kitchen. There were gouge marks in the floors. 4. The dining room indicated a wall partially repaired with peeling caulk. The caulk was not sanded or painted. The bottom of the TV was stained yellow. There were two overbed tray tables in marred and stained. There was dirt and grime around the perimeter of the dining room, peeling walls around the perimeter of the dining room. The blinds and windows were dirty, the doors to the courtyard			

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	were soiled from hand prints. There was dirt in the threshold of the doors. The doors did not close completely. There was dirt around the ice chest in the dining room. 5. At the end of the south hallway the ceiling had been repaired. There was visible patching and tape on the ceiling. The patching was peeling with cracks visible. The patching was not sanded or painted. 6. At the end of the north hallway, the ceiling had been repaired. The top layer of the drywall was peeled off and was covered by plastic sheeting. There were water stains visible on the sheeting with brown staining on one side. There were water marks on the wall and ceiling. There was patching that was done on the part of the ceiling that was not sanded and not painted. 7. In the main hallway and the hallway leading to the dining room, the baseboards were peeling up and were soiled with dirt and grime. An observation of housekeeper #1 cleaning the dining room on 06/02/2011 after lunch indicated the housekeeper swept and mopped the floors but did not clean around the			

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	baseboards or doorway. An interview the maintenance supervisor on 06/02/2011 at 9:45 AM, indicated "...the cracks in the ceiling are from the rusting drip pans from the air conditioners. I have the drip pans but I haven't replaced them. I will repair the ceiling after I replace the drip pans." He also indicated he does not have an assistant maintenance person and fixing the ceiling is a two person job. The cracks in the hallway were a result of work due to the settling of the building. The work was completed in February and he is waiting to fix it. An interview with housekeeper #1 on 06/02/2011 at 10:20 AM, indicated there was no set schedule for cleaning. "I know they all have to cleaned. The dining room is cleaned three times a day after each meal, the shower rooms are cleaned in the morning and after showers are done and I clean the hallways all day long." 3.1-19(f)			

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F0272 SS=E	The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. Based on observation, interview, and record review, the facility failed to ensure individualized activity assessments and assessments for restraint use were completed for 4 of 12 residents reviewed for	F0272	Residents #2 and #7 were each assessed individually to determine their activities preferences. Their activities preferences were care planned and a daily activity sheet was put in place to track the resident's participation.Residents #19 and	06/20/2011

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	assessments in a stage two sample of 28 residents. (residents' #2, #17, #19, #27) Findings Include: 1. The record for resident #17 was reviewed on 06/02/11 at 8:45 a.m. Diagnoses included, but were not limited to, osteoarthritis, glaucoma, Alzheimer's disease, dementia, hypertension, diabetes, prostate cancer, and unavoidable weight loss. A significant change Minimum Data Set (MDS) Assessment dated 03/17/11 indicated on the cognitive assessment portion, Resident #17 identified the accurate day, the accurate month within 5 days, and the accurate year. The MDS indicated Resident #17 had not presented behaviors or mood concerns during the assessment phase. The MDS indicated Resident #17 had not exhibited rejection of care. The activity assessment was marked that Resident #17 indicated activities were not important at all. The record lacked documentation of an activity assessment with Resident #17's individualized interests. During an interview on 06/01/11 at		#27 each had a restraint assessment put in place by the Physical Therapist and the D.O.N. The Physician's Orders were clarified to list the reason for restraints and documentation was put in place to support their use. The use of the restraints was care planned immediately.All residents have the potential to be affected by this deficient practice. Each resident now has an activities preference sheet listing their likes and dislikes.Each resident also has an individualized activities care plan and an activities attendance log. All restraints will be assessed and monitored. A restraint release sheet will be put in the ADL book.These new procedures will be monitored weekly by the Social Services Director and the D.O.N. This will be reviewed for effectiveness by the Q.A. Committee on a quarterly basis.	

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	8:50 a.m., Resident #17 indicated there were no evening activities. During an interview and observation on 06/03/11 at 10:45 a.m., Resident #17 showed his boy scout patches and indicated he was a chaplain for the boy scouts. Resident #17 indicated he went on several boy scout camping trips. During an interview with the DoN on 06/03/11 at 2:00 p.m., the DoN indicated she was not aware that Resident #17 was a boy scout and interested in the boy scouts. 2. The record for Resident #2 was reviewed on 6/2/11 at 1:55 P.M. Current diagnoses included, but were not limited to, sick sinus syndrome, hypertension, cardiovascular disease, non-insulin dependent diabetes mellitus, rheumatoid arthritis, and gastroesophageal reflux disease. The Initial Activity Assessment, completed in 2007, did not document a listing of activities the resident enjoyed. It indicated the resident was alert and oriented x 3 (to person, place, and time), able to make her needs and wants known, and that she liked large and small group activities. The last entry in the Activities section			

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	of the record was from 1/20/11 for the Quarterly MDS Assessment. It indicated she was continuing her routine, attended activities of her choice, Bingo, devotions, birthday parties, music programs, and conversing and interacting with staff and peers. The record lacked an activity care plan. The care plans had last been reviewed in April, 2011. During an interview on 6/3/11 at 9:00 A.M., the Social Services/Activity Director indicated the Activity Care Plan should have been in the record and she didn't know what happened to it. She also indicated assessments used to be done which listed all of the residents past and current activity interests, but we changed forms, and Resident #2's form is the form currently in use. The Social Service/Activity Director also indicated at that time she did not know where the activity care plan or activity preferences list were if they were not in the record. **3.** The record for Resident #27 was reviewed on 6/2/11 at 9:35 A.M. Current diagnoses included, but were not limited to, diabetes mellitus,			

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	dementia, Alzheimer's Disease with aggression, glaucoma, hyperlipidemia, gastroesophageal reflux disease, depression, and hypertension. The June, 2011, Recapitulation of Physician's Orders indicated a lap buddy [type of restraint] was to be used when up in wheel chair for "safety".. and had been originally ordered on 4/18/11 as a telephone order at 1:00 P.M.. During observations of Resident #27 on 05/31/11 at 12:00 P.M., 06/01/2011 at 8:00 A.M., and 09:03 AM a lap buddy was in place in Resident #27's wheel chair during lunch on 5/31/11 breakfast at 8:00 A.M., and again at 9:00 A.M. while she was in her room. The Nurses Notes from 4/5/11 through 4/22/11 did not indicate a reason the lap buddy was ordered. No fall was documented. No constantly rising from chair had been documented. Resident #27's record lacked documentation of a Restraint Assessment, a Consent for use of a restraint, or a Restraint Record which would document the times the			

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	resident had been restrained and released from the restraint. The record also lacked a Care Plan for the use of a lap buddy. The physician's order lacked a medical reason or indication for the use of the lap buddy restraint. The Fall Risk Assessment, dated 4/5/11, indicated no history of falls, had balance problems during transitions, leaned forward at times once in the wheel chair, The analysis of findings indicated "Res. (resident) has no recent, documented falls, but does have reduced safety awareness 2 (secondary to) dementia. Also @ [at] risk due to vision & use of lexapro (an antidepressant) on a daily basis." On 6/2/11 at 10:45 A.M., during an interview with the DON, she indicated she was unable to find a restraint assessment, care plan, consent, or restraint documentation. During an interview with the DON on 6/2/11 at 1:45 P.M., she indicated the lap buddy was put on without an assessment or documentation or consent being done. 4 .Resident #19's record was reviewed on 06/02/2011 at 1:00 P.M. Diagnoses included, but were not limited to, dementia, hypertension			

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	and encephalopathy. On the following dates resident #19 was observed lying in bed with 2 full side rails up with the bed against the wall: 05/31/2011 at 11:40 A.M., 06/01/2011 at 8:40 A.M., and 06/02/2011 at 10:20 A.M. A current Minimum Data Set (MDS) assessment dated 02/24/2011, indicated resident #19 had not had a fall since admission and required the use of bed rails daily. The MDS indicated resident is totally dependent on staff assistance for bed mobility, transfers, dressing and toileting. A current care plan dated 03/09/2011, indicated resident #19 was at risk for falls secondary to cognitive impairment. Interventions included, but were not limited to, bed in low position and active range of motion (AROM). The care plan indicated the resident was unable to turn/reposition independently. There was no care plan for the use of restraints. A physicians order dated 04/18/2011, indicated resident #19 was to have "side rails up when in bed." The record lacked documentation of assessment for the restraints or a			

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	restraint flowsheet. An interview with CNA #1 on 06/02/2011 at 10:20 A.M., indicated the resident was a fall risk and that was the only way she could have the side rails up. An interview with the Director of Nursing (DON) on 06/02/2011 at 1:15 P.M., indicated the resident scoots and moves around in the bed and that was why the side rails were up. 3.1-31(a)			

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F0278 SS=D	The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. Based on record review and interview, the facility failed to ensure Medicare Stay information on the MDS (minimum data set) assessment was accurately reported for 3 of 3 residents reviewed for Medicare Stay in a sample of 28 (Residents # 17, # 30 and # 28). Findings include: A current undated facility policy titled "Comprehensive Assessment/MDS	F0278	A request for correction was submitted for the three MDS' that were inaccurately coded. This information was submitted to both the state and federal database on June 20, 2011.All resident's MDS' were checked for Medicare Stay coding errors. No other coding inaccuracies were found.A check system has been put in place to ensure correct coding of the MDS. All MDS' will be checked by the MDS Coordinator, Social Services Director, and the D.O.N. to ensure the accuracy of the	06/20/2011

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	Policy" and provided by the Director of Nursing (DON) on 6/6/11 at 9:30 A.M. indicated: "... Policy: It is the policy of (name of facility) to perform a ... accurate, ... reproducible assessment of each resident's status ..." Liability notices for Medicare were reviewed on 6/2/11 at 1:15 P.M. for the following residents, # 17, #30 and # 28. The MDS question, "Has the resident had a Medicare-covered stay since the most recent entry? was answered incorrectly by marking "yes". During a telephone interview with the MDS Coordinator on 6/2/11 at 1:30 P.M. she indicated she was answering the question yes because she thought it was about a hospital stay. She did not think it was about the facility stay. She also indicated she would be sending corrections for the errors. During an interview with the Business Office Manager at the same time she indicated there were no residents in the facility with medicare benefits. 3.1-31(g)		MDS before they are transmitted. A MDS meeting was held on June 16, 2011 to review the R.A.I. manual to ensure understanding of the proper coding of a Medicare hospital stay.To ensure the accuracy of the MDS, the MDS Coordiantor will re-check the MDS before they are signed as complete and accurate. If no errors are found, the MDS will be signed and placed on the resident's chart and then transmitted.The Q.A. Committee will monitor the progress on a quarterly basis. If problems occur, the Q.A. Committee will review the problem and corrective actions will immediately be taken.	

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F0280 SS=D	The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on record review and interview, the facility failed to ensure care plans were updated and revised with each assessment and change in resident's condition, and failed to ensure families were invited to care plan conferences, for 3 of 12 residents reviewed for care plans in the stage 2 sample of 28 (Residents #16, #18, #27). Findings include:	F0280	Care plan conference records have been reviewed and revised. Phone calls have been made and invitations have been sent to all resident's family members according to the resident's care plan date. A care plan invitation log will be maintained to keep track of family invitations to the care plan meetings.All resident's charts were reviewed and revised. All residents have the potential to be affected by this deficient practice.All resident's care plan meetings are scheduled according to their admission date,	06/20/2011

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	1. The record for Resident #16 was reviewed on 6/1/11 at 3:30 p.m. Diagnoses included, but were not limited to, behaviors with aggression, Alzheimer's dementia, hypertension, anemia, ETOH [alcohol] Abuse, hyperlipidemia, and depression. The most recent MDS (Minimum Data Set) assessment was a quarterly assessment, dated 4/21/11. The "Care Planning Conference Record," included with the resident's care plan, was dated 2/02/11, and checked as an admission care planning conference. The Director of Nursing, Social Services Director and MDS Coordinator signed the record on this date. The rest of the record was blank, with no documentation to indicate another care planning conference had been held for Resident #16 since 2/02/11. Review of the resident's care plans indicated all problems were dated 2/02/11 with no revision dates documented. Interview with the Social Services/Activities Director, on 6/02/11 at 9:35 a.m., confirmed the care plans were dated 2/02/11, and documentation of care plan revision was lacking, and indicated it was an "oversight." The record for Resident # 18 was		significant changes, or discharge date. A yearly schedule is made for all disciplines to follow.All MDS' have been appropriately reviewed and revised. A care plan conference log and family invitations have been put in place with scheduled dates and times of the care plan conference.The MDS Coordinator and Social Services Director will ensure all care plans are updated according to the care plan schedule. This will be monitored monthly by the Administrator and reviewed quarterly by the Q.A. Committee	

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	reviewed on 6/2/11 at 1:15 P.M. Diagnoses for Resident # 18 included, but were not limited to, Alzheimer's disease, advanced dementia, Hypertension, Cataracts, Anorexia and Anemia. The Care Planning Conference Record for Resident # 18 lacked documentation the family, resident or Legal Representative was notified of a care plan meeting for 2/2/11. 3. The record for Resident #27 was reviewed on 6/2/11 at 9:35 A.M. Current diagnoses included, but were not limited to, diabetes mellitus, dementia, Alzheimer's Disease with aggression, glaucoma, hyperlipidemia, gastroesophageal reflux disease, depression, and hypertension. During an interview on 6/1/11 at 12:45 P.M. with Resident #27's son, he indicated he had not been invited to his mother's care plan conferences. During an interview with the SS/Act (Social Service/Activities) Director on 6/2/11 at 10:00 A.M., she indicated after speaking with RN #3 (RN/MDS [Minimum Data Set Assessment] Coordinator) RN#3 had stopped sending notices to families approximately 6 months ago due to lack of attendance and response, so the "ball got dropped" as far as inviting families to care plan meetings.			

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	3.1-35(c)(2)(C)			
F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to ensure adequate indications for the initial use of an antipsychotic medication and also failed to monitor behaviors and attempt gradual dose reductions for residents on antipsychotic medications, for 2 of 10 residents reviewed for unnecessary medications (Residents #16, #25). Findings include:	F0329	Resident #16:Resident #16's medical condition was discussed with the Physician. The Physician will try a medication reduction in 6 months. The care plan was updated with the behaviors and the medication that the resident is receiving. A behavior monitoring log, with interventions that will assist in redirecting the resident when an abnormal behavior occurs, has been put in place.All residents have the potential to be affected by this deficient practice. Other resident's medical records were	06/21/2011

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	1. The record for Resident #16 was reviewed on 6/1/11 at 3:30 p.m. Diagnoses included, but were not limited to, behaviors with aggression, Alzheimer's dementia, hypertension, anemia, ETOH [alcohol] abuse, hyperlipidemia, and depression. A quarterly MDS (Minimum Data Set) assessment, with a reference date 4/21/11, indicated the following: Physical behavior symptoms directed toward others, other behaviors not directed toward others, wandered, and reject evaluation/care necessary to goals for health/well-being - behaviors occurred 1 to 3 days in the assessment period. Behavior assessments, dated 4/15 - 4/21/11, indicated wandering, pacing, argumentative, smeared BM (bowel movement), verbally abusive to staff, peeping into rooms, and very verbal. Review of physician orders indicated Risperdal (antipsychotic medication) was ordered on 4/01/11, 0.25 mg by mouth twice a day. On 4/09/11, the Risperdal was increased to 0.50 mg twice a day. On 5/13/11, the Risperdal was increased to 0.75 mg every bedtime and continue Risperdal 0.5 mg every A.M.		checked for psychtropic medications to ensure each has been reviewed for a 6 month medication reduction.A behavior monitoring sheet was put in place and the care plan was updated. The Physician will consider a medication reduction in 6 months.This will be monitored by the D.O.N. and the Social Services Director. The Q.A. Committee will review for compliance on a quarterly basis.Resident #25:The Physician determined that a psychtropic medication reduction would not be benificial to the resident at this time due to the resident's long term use of the medication. The Physician's decision was documented in the resident's chart. The Physician will be asked to consider the medication reduction again in 6 months.All other residents have the potential to be affected by this deficient practice. All charts were checked and no other residents were found to be affected.Medications will be monitored by the pharmacy. They will notify the facility when a medication reduction is due. The Physician has the authority to accept or reject the pharmacy's recommendations. The Social Services Director spoke with the mental health provider. They will see the residents who do not display behaviors, on a yearly basis.This will be monitored	

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	A psychiatry progress note, dated 4/11/11, indicated "...resident...referred due to her level of confusion and wandering behaviors with an insistence that she is on staff in the ECF (extended care facility)...symptoms effect functioning as client is so fixated upon her supposed responsibilities as an employee that she is neglectful and disinterested in maintaining her own physical health. Diagnosis dementia...Goals-Client does not identify a goal of care but ECF staff is desirous of medication that may deal with 'agitation and wandering....'" The recommendations included to consider starting Risperdal 0.25 mg twice a day. Review of nurses' notes from 4/01/11 through current indicated the following entries regarding the resident's behaviors: "4/4/11 10 p -Alert to self. Disoriented to other spheres. Argumentative when redirected about something she is doing. Appears to wait until res in adjoining room goes to the br (bathroom), then she gets up and goes in trying to make her come out. Reminded again not to do this and redirected to another BR. Started arguing and rambling....		monthly by the D.O.N. and the Social Services Director. The Q.A. Committee and Medical Director will review this on a quarterly basis.	

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	(documented by night nurse, RN #3) 4/8/11 3:30 a.m.- Res has been up all noc (night). Sitting in DR (dining room). Refused to go to bed. Upset with me every time I went to the med cart. Said I had no right to be doing that. Is wearing a scrub set and still thinks she is the nurse. When I left the nurses' station, she come and sit down behind the desk and said she was in charge. It was very difficult to get her to move from behind the desk. She had been trying to get back here all shift with her walker but walker would not fit. On last attempt she left the walker in the DR and took a seat. She is very argumentative and refused to move until she was ready. (night nurse, RN #3) 4/11/11 (no time documented) ...resistive to care at times.... (documented by DON) 4/11/11 9 p - res very argumentative with me. Thinks she is the nurse - trying to follow me around to see 'what I am doing. Had to be told several times not to try to attend to other residents' needs. Wanted to [sic] my title and what I was doing here. Tried to sit behind the nurses' station. When asked to go to her room she said I was trying to make her 'lose her job.' Trying to pick up documents @ desk and read them. Unable to easily redirect." (night			

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	nurse, RN #3) 4/15/11 5 a - Has been awake entire shift. Pacing back and forth to nurses' station. Attempting to argue with staff. Going through BR into adjoining room and trying to tell occupant what to do. When approached by staff to exit room said 'you can't make me do anything I have every right to be here.' Minutes after being escorted back to her room her mood changed and she was so nice only to repeat scenario of pacing roaming and arguing. (night nurse, RN #3) 4/15/11 1300 - Res very agitated and resistive to care. wandering halls, yelling at staff. urinary frequency appears increased resident toilets self. MD in to see res new orders as noted. (documented by DON) 4/18/11 8 p - Res is noted squatting over the trash can using it for a toilet to have a BM. Had a large BM all over the floor and in the can. Smeared it all over her and had a tissue and was trying to wipe. Assisted to the shower because she had smeared too much BM to just wash it off. When she got in the shower she started screaming and hollering 'help, help, help.' After she had a shower and had a brief applied, she took the brief off, hung it up on the walker sat on the toilet she is very			

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	argumentative and confrontational. (night nurse, RN #3) 4/25/11 1530 Res alert to name only. speech clear confused to time and place easily agitated requires assist with ADLs (activities of daily living). res uses trash can as toilet redirected per staff.... (DON) 5/2/11 8 p - alert and oriented to self only. Rarely able to locate room. Intrusive into conversation of staff. Always had something to inject into the conversation. Easily agitated especially when she thinks she is the nurse and you won't answer her questions. Usually incont of B & B but voids in inappropriate places at x's (times) (night nurse, RN #3) 5/9/11 2 p.m. - ....voids in trash can.... 5/13/11 10 a.m. - (Doctor from mental health center) in to see resident recommendations referred to PCP (Primary care physician). New orders as noted. (DON) 5/16/11 9 p - Risperdal (arrow up) on 5/13/11 and res is resting better @ noc. Cont to be argumentative when approached but has not been camping @ the nurses station trying to run the shift...No episodes of voiding or BMs in wastepaper basket X several days. (night nurse, RN #3) 5/23/11 1400 ...calm and cooperative.... (DON)			

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	5/30/11 8p - A & O to self only. Noted to be much more pleasant less argumentative and easier to render care to since med change on 5/13/11. It has made a wonderful difference. She will now allow noc shift staff to assist her to bed and with hs (bedtime) care. More pleasant in am when she wakes up and rarely wanders @ noc. Rests well. Cont (continent) of B & B with assist/reminders to toilet. Skin intact. (night nurse, RN #3)." Review of Social Service progress notes indicated the last entry was dated 2/10/11 and indicated a psychiatric evaluation was ordered on this date; resident is exhibiting wandering, delusional behaviors and agitation. A Social Service Documentation Tool with the last assessment, dated 4/15-4/21/11, indicated the resident displayed inattention and disorganized thinking. The antipsychotic medication, Risperdal, was not addressed. The resident's care plan was dated as last revised on 2/02/11. One of the problems indicated the following: "The resident demonstrates cognitive			

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	impairment related to: Diagnosis of dementia (check marked). Symptoms are manifested by: Impaired decision making, poor impulse control, becoming agitated during care and resisting necessary assistance (check marked)." The goal was, "The resident will make no decisions that adversely affect her health x 90 days." Approaches included, but were not limited to: Discuss med regimen with MD to assess and rule out possible side effects or contraindications r/t medications prn (as needed). [mental health center] to evaluate and treat as needed. Another problem, dated 2/02/11, was, "The resident displays behavioral symptoms related to: Dementia of the Alzheimer's type or other dementia (check marked) Wandering, pacing, motor agitation (check marked) Verbal abuse/aggression (check marked) Refusing/resisting care (check marked) "Voiding & BM in trash can thinking it is a toilet" was written in. The goal was, "the resident will comply with staff redirection and			

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	behave in a safe and respectful manner, 7 of 7 days per week by 90 d (days)." The care plan did not include individualized, non pharmacological interventions to address the resident's behaviors, which were documented to mostly occur on the night shift. The care plan had also not been revised since 2/02/11, before the resident's documented behaviors and the use of the antipsychotic medication, Risperdal. Interview with the Social Service/Activities Director at 9:35 a.m. on 6/02/11, confirmed the care plan was dated as last reviewed on 2/02/11, and it was an "oversight." On 6/2/11 at 2:20 p.m., the Social Service/Activities Director provided the Psychotropic Drug and Behavior Monitoring book, and indicated this to be where residents' behaviors were monitored. There was no form for Resident #16 in this book. At this time, the Social Services/Activities Director confirmed documentation of behavior monitoring was lacking for Resident #16. 2. The record for Resident #25 was reviewed on 06/01/11 at 2:57 p.m.			

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	Diagnoses included, but were not limited to, emphysema, unspecified type schizophrenia, senile dementia uncomplicated, cataracts, mild chronic obstructive pulmonary disease, and constipation. The most recent quarterly Minimum Data Set (MDS) Assessment, dated 04/28/11, indicated Resident #25 had a diagnosis of schizophrenia. The MDS indicated Resident #25 had no behaviors or mood observations during the assessment phase. The most recent recapitulation dated 05/31/11, indicated current physician's orders with an original date of 03/18/08, "... chlorpromaz (antipsychotic) tab 50mg take 1 tablet by mouth twice daily...trifluoperaz (antipsychotic) tab 2mg take 1 tablet by mouth twice daily...." A pharmacy review of the medication regimen was dated 05/25/11. A current care plan with the most recent date of 5/11/11, indicated a potential for psychosis. Interventions included chlorpromazine and trifluoperazine. The record lacked documentation of mental health services or a recent			

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	mental health evaluation for Resident #25. During an interview on 06/02/11 at 10:30 a.m., The Activities/Social Services Director indicated she notified the case manager via telephone and was informed if the resident did not exhibit behaviors, the case is closed. The Activities/Social Service Director indicated the facility physician manages the resident's medications. During an interview on 06/02/11 at 2:18 p.m., the DoN indicated, "He's been on the thorazine for so long, and he needs it." She indicated she was calling the pharmacists. During an interview on 06/03/11 at 9:41 a.m., the DoN indicated she had not received a return phone call from the pharmacists. During an interview on 06/03/11 at 12:45 p.m., the DoN indicated the pharmacists called back. The DoN indicated the pharmacists reported a Gradual Dose Reduction (GDR) was not done on a resident that has an appropriate diagnoses for the medicine and a doctor"s statement in the progress note that indicated to continue current plan of care.			

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	155683	A. BUILDING 00 B. WING	06/06/2011

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	The record for Resident #25 lacked documentation of a GDR for the antipsychotic medicines. 3.1-48(b)(2)			

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F0356 SS=C	The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation and interview, the facility failed to ensure nurse staffing data was posted daily and included the total number of staff and total hours worked for each shift. The facility also failed to maintain the daily nurse staffing data for 18 months. This had the potential to affect all	F0356	The posted nurse staffing forms were updated to show the number of staff working and the hours worked on each shift.All residents were identified as having the potential to be affected by this deficient practice. This was corrected by updating the posted nurse staffing form.The nurse staffing forms are placed at	06/13/2011

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	residents in the facility and their visitors. Findings include: During initial tour on 5/31/11 and 10:05 a.m., nurse staffing data was observed posted on the wall just inside the front door. It was dated 5/25/11 and listed actual hours worked and total hours worked, for RNs, LPNs and CNAs. The number of staff was not listed, and the data did not indicate information for each shift. Staff posting observed on 6/01/11 at 10:30 a.m. was dated 5/31/11. Actual hours and total hours worked for RN, LPN, CNA were listed, but not per shift, and the number of staff was not indicated. Staff posting observed on 6/1/11 at 3:15 p.m. was dated 6/1/11, and did not indicate the census. The number of staff and actual hours worked per shift were not included, as in the above observations. During observation on 6/2/11 at 12:35 p.m., the same staffing for 6/1/11 was posted. The Director of Nursing (DON) was		the nursing station. The daytime charge nurse will be responsible for filling out the form at the change of shift. All nurses were shown the correct way to fill out the form.This will be monitored by the Administrator from Monday to Friday and by the charge nurse on weekends. The D.O.N. will be responsible for keeping the forms for 18 months.	

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	interviewed on 6/02/11 at 1 p.m. She confirmed they have not been including the required information for each shift and had not been including the number of staff worked. The DON was also not aware the posted daily nurse staffing data should be maintained for 18 months. 3.1.13(a)			
F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure sanitary conditions were maintained in the kitchen. This had the potential to affect 32 of 32 residents. Findings include: The initial kitchen tour on 05/31/2011 at 10:05 AM, indicated an undated open bag of corn meal in the dry storage, and an undated open gallon of chocolate milk and 2 liter of diet	F0371	All of the food in the kitchen was checked for proper dating, labeling, and storage. The significance of maintaining sanitary conditions was covered in an inservice. The inservice covered the following: 1. Proper handwashing & turning on/off the faucet 2. Proper finger nail length 3. The use of hair nets 4. The proper use and disposal of gloves 5. The re-emphasis of maintaining sanitary conditionsAll residents have the potential to be affected by this deficient practice.	06/17/2011

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	soda in the refrigerator. The Dietary Manager had painted long artificial nails. During the kitchen observation on 06/01/2011 at 7:50 AM, the Dietary Manager was observed washing her hand upon entering the kitchen. The Dietary Manager dried her hands with a paper towel. She then picked up the lid on the garbage can to dispose of the paper towel. The Dietary Manager then placed one glove on one hand. The Dietary Manager then picked a piece of paper off the floor with her ungloved hand. She placed the paper on the countertop and then placed a glove on the ungloved hand. She then touched the water faucet in the sink, and opened the refrigerator without changing gloves. The Dietary Manager then began to serve pureed food and coffee to the residents. The Dietary Manager did not wash her hands after touching the garbage can or picking the paper off the floor. During the kitchen observation on 06/01/2011 at 8:20 AM, the Dietary Manager took her hairnet off while standing in the doorway while still in the kitchen. The Dietary Manager was less than a foot away from the steam table where breakfast was being served. The Dietary Manager, took		Multiple iinservices have been given since June 6, 2011 to correct the problem.A guide displaying proper handwashing techniques has been placed over the sink in the kitchen. The kitchen staff have been inserviced over proper handwashing, proper finger nail length, the use of hair nets, the proper use and disposal of gloves, the proper dating and storage of food, and the re-emphasis of maintaining sanitary conditions.A new dietary manager will be hired and will be responsible for monitoring the kitchen for compliance on a daily basis. Until the new dietary manager is in place, the Administrator and the Dietary Consultant will monitor the kitchen for compliance. The Q.A. Committee will also review for compliance on a quarterly basis.	

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	the hairnet off and then placed it back on her head. A current facility policy titled "Handwashing procedure" provided by the Dietary Manager on 06/02/2011 at 2:25 PM indicated "...to assure effective handwashing, nails must be kept short. When turning faucets and when handling the lids of preventing [sic] cans, use paper towels..." An interview with the Dietary Manager on 06/02/2011 at 2:00 PM indicated she was still in school and she doesn't do much cooking. She indicated the facility did not have a policy regarding the wearing of artificial nails in the kitchen. 3.1-21(i)			
F9999	Based on record review and interview, the facility failed to ensure dementia training was completed for two of five new employees and for one of seven current employees reviewed for inservice training.	F9999	All new employees have completed the required 6 hours of dementia training. All current employees will receive 3 hours of dementia training annually. All residents have the potential for being affected by the deficient practice. All employees dementia	06/10/2011

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	Findings include: Review of employee records on 06/03/2011 at 10:45 AM, indicated initial dementia training had not been completed for two employees. CNA #2 was hired on 09/07/2010. Cook #1 was hired on 09/13/2010. Annual dementia training had not been completed for RN #1. An interview with the Social Services Director on 06/03/2011 at 12:35 PM indicated ..."they probably still need to do so. Our policy is to do them every six months. Our next inservice will be in June." 3.1-14(u)		training was audited by the Assistant Administrator. It was determined that all other employees had received their dementia training.A list of all current employees was audited to ensure that all had received dementia training. All new employees will have their full 6 hours of dementia training scheduled upon hire. A copy of all new employees' dementia training schedules will also be given to the Social Services Director, the D.O.N., and the Adminisrator for monitoring and compliance. This will be reviewed by the Q.A. Committee on a quarterly basis.	